Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 11-1-02.

   b. The request was received on 7-2-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA
   c. EOB
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   No Response noted in the dispute packet.

3. Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 7/11/02. There is no Carrier initial or 14 day response to this medical fee dispute noted in the file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 6-27-02:
   "On Date of Service November 1, 2001, a thirty (30) day rental for a neuromuscular stimulator (Procedure Code E1399) was disallowed because of, 'Charges not identified and/or quantified'. Further explanation of reduction was 'not documented'. …We coded appropriately and provided all of the necessary documentation. We even submitted an Appeal Letter and made two more phone calls, none of which were returned by the Carrier nor their auditors."

2. Respondent: No response noted in the dispute packet.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11-1-02.

2. The Carrier has denied the disputed services as reflected on the EOB as, "N – DISALLOWED; CHARGES NOT IDENTIFIED AND/OR QUANTIFIED."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
11-1-02	E1399	$240.00	$-0-	N	DOP	MFG: Durable Medical Equipment (DME) Ground Rules (II) (IX)	The Carrier has denied the disputed service as "N". Review of the dispute packet supported the claimant's diagnosis; prognosis and expected duration of the equipment were documented. Therefore, reimbursement is recommended in the amount of $240.00.
Totals		$240.00	$-0-				The Requestor **is entitled** to reimbursement in the amount of **$240.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$240.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 03rd day of December 2002.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll